



Dana Mckennon, Psy.D., Ed.S.
Licensed Clinical Professional Counselor

175 Olde Half Day Rd
Suite 140-10
Lincolnshire, IL 60069

NEW PATIENT REGISTRATION FORM

Patient Information (please print clearly)

Patient Name _____ Patient Home Phone () _____
 Patient Home Address _____ Patient Cell Phone () _____
 _____ Patient Work Phone () _____
 _____ Patient Date of Birth: _____

Patient gender: ___ Male ___ Female Patient marital status: ___ Single ___ Married ___ Other

Patient employed: ___ Employed ___ Student Employer/school: _____

Billing Information:

Name of responsible party: * _____
 Last First Middle

Address: _____ Home/ Cell Phone: () _____
 _____ Work Phone: () _____

*No third party billing. Responsible party must be present to sign for financial responsibility

Billing Information: Bill my insurance? ___ Yes ___ No Please provide a copy of your ins. card
PRIMARY INSURANCE

Insurance company Name: _____ Insured's name: _____
 Insurance company Address: _____ Insured's employer: _____
 _____ **Group # or name:** _____

Insured's date of birth ___/___/___ **Policy #:** _____

Insured's phone number () _____

Authorization #: _____ Patient's relationship to insured: ___ Self ___ Spouse ___ Child

OFFICE USE ONLY: Self Pay

Account #: _____ Diagnosis Code: _____ Statement sent to home? ___ Yes ___ No
 Referral Source: _____ Special Notes: _____ **FEE SCHEDULE**



Notice of Privacy Practices- Brief Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy

Please note that Kids Counseling, PC is providing this document to you subsequent to the Health Insurance Portability and Accountability Act (HIPAA). Our office has always and will continue to maintain the highest standards regarding our patients' personal information. You can be assured that our practice goes beyond what is required by HIPAA. Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This form is a summary of the full NPP which is available if you would like more information.

We will use the information regarding your health, which we obtain from you or from others mainly to provide you with treatment, to arrange payment for our services and for some other business activities which are called, in the law, health care operations. After you have read this NPP and discussed it with your doctor and/or therapist we will ask you to sign a Consent Form to allow us to use and share your information as needed. Please note that Kids Counseling, PC will continue to have you complete releases of information in addition to this document. If you do not consent and sign this form, we cannot treat you.

Kids Counseling, PC utilizes an electronic billing service to process claims via the internet. Rest assured that our office has taken great care in selecting the billing company with whom we have contracted. Each step in the process is encrypted to ensure the highest standard in privacy regarding sensitive personal information.

If there is a need to disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an authorization form to allow this. Of course we will keep your health information private, but there may be times when the law requires us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization which is

able to help prevent or reduce threat.

2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these which do not happen very often. They are described in the longer NPP.

Your Rights Regarding Your Health Information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place whichever is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records. A fee may be associated with this service. Contact our Privacy Officer to arrange to see your records.
4. If you believe the information in your record is incorrect or missing important information, you can ask us to make changes (called amending) to your health information. You must make this request in writing to your doctor and/or therapist or our Privacy Officer. In your request, you must tell us the reason(s) you want to make the changes.
5. You have the right to a copy of this notice. If we change the NPP we will notify you as soon as possible and you can always get a copy of the NPP from our Privacy Officer .
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, Dana Mckennon. She can be reached by phone at (630) 373-0241.

The Effective date of this notice is April 14, 2017.

I understand Kids Counseling’s commitment to my privacy and my rights under HIPAA.

Signature of Patient: _____ Date: _____

Parent/Guardian: _____ Date: _____
(Please specify relationship to patient)

Signature of Clinician: _____ Date: _____



Patient Email/Texting Informed Consent Form

To ensure the highest level of confidentiality, it is the preference of Kids Counseling, PC to speak via telephone call and to send reports to patients through our EMR patient portal and/or fax. However, it is up to the discretion of you as the patient or patient's guardian to engage in communication via email and/or text with proper expressed written consent. Please carefully consider the following and indicate your preferences.

Risk of using email/texting: The transmission of patient information by email and/or texting has a number of risks that patients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

1. Emails, texts, and attachments can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
2. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
3. Backup copies of emails, texts, and attachments may exist even after the sender and/or the recipient has deleted his or her copy.
4. Employers and on-line services have a right to inspect emails and its attachments sent through their company systems.
5. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
6. Emails, texts, and attachments can be used as evidence in court.
7. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of email and texts:

Clinicians cannot guarantee, but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Clinicians are not liable for improper disclosure of confidential information that is not caused by their intentional misconduct. Patients/Parents/Legal Guardians must acknowledge and consent to the following conditions:

1. Email and texting is not appropriate for urgent or emergency situations. Clinician cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.

2. Email and texts should be concise. The patient/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
3. Patients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
4. Texts should be primarily used to make or change appointments and emails can be used to communicate lengthier information.
5. Emails, texts, and attachments may be filed into the patient's medical record.
6. A clinician will not forward patient's/parent's/legal guardian's identifiable emails, texts, and/or its attachments without the patient's/parent's/legal guardian's written consent, except as authorized by law.
7. Clinicians cannot respond to "all" if a parent/guardian/patient chooses to include other parties not covered in a signed consent for release of information.
8. A clinician is not liable for breaches of confidentiality caused by the patient or any third party.
9. All parties shall respect each other's assumed confidential communication by not forwarding, carbon copying, or blind carbon copying other parties.

3. Patient Acknowledgement and Agreement:

- I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my clinician(s) and me.
- I consent to the conditions and instructions outlined as well as any other instructions that my clinician(s) may impose to communicate with me by email or text. Kids Counseling, PC may communicate with me via email and/or text to the following (Do not list a contact if you do not wish to communicate via one or both methods)

Phone number(s): _____
 Email address(es) _____

_____ ***I decline to communicate via email or text as outlined in this document***

Signature of Patient: _____
 Date: _____

Parent/Guardian: _____ Date: _____
 (Please specify relationship to patient)

Signature of Clinician: _____ Date: _____



VOICEMAIL MESSAGE CONSENT:

In order to best serve your mental health needs, Kids Counseling, PC will confirm your appointment one business day in advance via an automated service. Additionally, your clinician will return your call/message if they are not presently available.

_____ Kids Counseling, PC may leave a message on patient's/family voicemail confirming your appointment and/or information you request regarding your treatment.

OR

_____ Kids Counseling, PC may **not** leave a message on patient's/family voicemail.

I understand that I have the right to revoke this authorization at any time without penalty.

Signature of Patient: _____ Date: _____

Parent/Guardian: _____ Date: _____
(Please specify relationship to patient)

Signature of Clinician: _____ Date: _____



FEES FOR CLINICAL SERVICES

INDIVIDUAL PSYCHOTHERAPY 30 minutes	\$40.00
INDIVIDUAL PSYCHOTHERAPY 45 minutes	\$85.00
INDIVIDUAL PSYCHOTHERAPY 60 minutes	\$135.00
FAMILY PSYCHOTHERAPY	\$120.00
GROUP PSYCHOTHERAPY	\$50.00 (Selective Mutism only)
DIAGNOSTIC INTERVIEW (AND TREATMENT PLAN)	\$180.00
PSYCHOLOGICAL ASSESSMENT and ACADEMIC TESTING	\$100 each hour

***NOT BILLABLE TO INSURANCE**

Cash Rates

*LETTER WRITING AND DOCUMENT PREPARATION	\$35/ 15 minutes
*IN PERSON REPRESENTATION IN LEGAL MATTERS	\$400 portal to portal each hour
*LEGAL DOCUMENT REVIEW AND PREP	\$250.00 each hour
*ACADEMIC RECORD REVIEW	\$40 each 15 minutes
*COLLATERAL CONTACTS	\$40 each 15 minutes
*DOCUMENT PREP (NON-TEST REPORT WRITING)	\$35 each 15 minutes
*IEP REPRESENTATION	\$100 each hour
*TRAVEL 10-25 MILES	\$35.00
*TRAVEL 26-50 MILES	\$70.00

o I understand that these rates may increase periodically, and that I will be informed prior to any rate changes.

o If using insurance for payment, I understand that if my clinician is in my network he/she has agreed to the usual and customary rate deemed appropriate by his/her contract with the insurance company. Further, I understand that my clinician may not charge me for the difference between the fees listed above and the agreed upon usual and customary rate, beyond the co-pay required by my insurance.

o I understand that **my co-pay or co-insurance is** _____. I understand that this fee is due at the time of service. If not using insurance for payment, I understand that I am responsible for the full charges of each session at the time of service, unless an alternate arrangement is made with the clinician.

o If using insurance for payment, I understand that my insurance company reserves the right to refuse payment for services they previously pre-certified. I understand that in such a case, I have the right to appeal to my insurance company for payment. I understand that I am ultimately responsible for services provided which are not covered by my insurance company.

Signature of **RESPONSIBLE PARTY**: _____ **Date**: _____

Signature of Clinician: _____ Date: _____



Consent to Release Information for Processing Benefits and Financial Agreement

- I understand that Kids Counseling, PC will bill my insurance company for clinical services rendered to me and/or a relative for whom I am legally responsible *IF* Kids Counseling, PC has an active contract with my insurance company. I authorize Kids Counseling, PC to release essential clinical information to my insurance company required to process claims (e.g., diagnosis, service code, treatment plans, progress notes, reports, etc.) I hereby assign, transfer and set over to Kids Counseling, PC all rights to collect payment for services rendered from my insurance company. I understand that this consent will remain in effect until all claims have been settled.
- I understand that any money that is considered PATIENT RESPONSIBILITY is due at the time of service (e.g., copays, coinsurance, deductible, or out of network insurance/private pay) and is different from amounts that are expected by insurance responsibility .
- I understand that it is my responsibility to have a valid credit card saved in Kids Counseling, PC' encrypted PCI compliant software program throughout the course of services
- I authorize Kids Counseling, PC to charge my credit card for any outstanding balance due at time of service and/or if the account for which I am responsible has an outstanding balance more than 60 days old.

Patient Name: _____

Cardholder Name: _____



CONSENT FOR THERAPY

I, _____, freely give my consent to take part in psychological treatment. I believe I understand the basic ideas, goals, and methods of this therapy. With enough knowledge, and without being forced, I enter into treatment. The clinician has addressed my questions and/or concerns regarding confidentiality and the therapy process. I understand that no guarantees regarding the outcome of therapy can be given. This agreement shows this clinician's willingness to use and share his or her knowledge and skills in good faith. Periodically during treatment, we will evaluate progress and may change treatment goals as needed. If it becomes clear that there is a need to transition care to another clinician for any reason (e.g., the nature of symptoms being addressed, misfit of personality, lack of progress etc.) I agree to discuss these concerns with my clinician and to participate in planning for transition to a new clinician if the issues cannot be resolved.

This agreement also shows my commitment to pay for services. I agree to pay the full disclosed amount per session, and to pay at each session. I understand and accept that I am fully responsible for this fee, but that my clinician will help me in obtaining payment from any insurance coverage I have. I also understand that in order to bill a third party (insurance) confidential information such as my diagnosis, treatment goals, and treatment progress may have to be released to the third party .

I understand that 24-hour notice is required for the **cancellation** of a session. If **24-hour notice** is not given, I understand that I am responsible for **a fee of \$50**, which is not reimbursable by my insurance. I understand that this charge is due in full at the time of my next session. The only exceptions are unforeseen or unavoidable situations arising suddenly.

My signature below means that I understand and agree with the points above

Signature of Patient: _____ Date: _____

I have discussed the issues above with this patient. My observations of this patient's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Signature of Clinician: _____ Date: _____

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.



Child Treatment Contract

(Please complete if the patient is a minor)

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Clinician Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and clinician regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having at least one closing session to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. In the state of Illinois, a child over the age of 12 is considered to have the legal right to refuse to have their parents inspect mental health treatment records. If your child is over this age, by signing this agreement, you acknowledge that your child has a right to privacy and that his/her therapist may not share the records with you without the child's consent.

It is the policy of our practice to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future. If your child is an adolescent, it is possible that he/she will reveal sensitive information



regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the parents, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of \$400 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

Clinician: _____ Date: _____



CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

(Note: Please make copies of this page for each party to whom you would like us to release information. If you were referred by your doctor, please at least complete this for your doctor for coordination of care)

I, _____, hereby authorize **Kids Counseling, PC** to release any and all records or information regarding _____
Name of Patient

(SPECIFIC NATURE OF INFORMATION TO BE DISCLOSED)

The following items must be checked and initialed to be included in the use and/or disclosure of other health information:

_____ Mental Health Information _____ Psychology Notes _____ Drug/Alcohol Diagnosis,
Treatment/Referral _____ HIV/AIDS Status _____ Sexually Transmitted Diseases

TO: _____ Date of next follow up appointment if scheduled: _____
(Receiving Agency or Person)

Phone: _____ Fax: _____
Address: _____

FOR THE PURPOSE OF: (Check All That Apply)

_____ Continuing Mental health/alcohol and/or drug abuse _____ Therapist transition
_____ Treatment or care and continuity of care _____ Housing and other arrangements and services
_____ Billing, payment and financial matters and arrangements _____ Other _____
_____ Consultation, advise and representation Regarding my condition and needs

This consent is valid until (Calendar Date): _____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not re-disclose it without my written authorization I also understand that if I refuse to consent to the release of information my clinician will not be able to coordinate care on my behalf.

(Minor Recipient, 12-17 years. Inclusive)

(Signature of Adult Patient or Parent & Date)

Witness: _____

Date: _____

NOTICE TO PATIENT AND RECEIVING AGENCY

Under the provisions of the Mental Health and Developmental Disabilities Act, HIPPA, and applicable Federal and State Alcohol and Substance Abused Confidentiality Acts, there may not be re-disclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. **A separate release is required for psychotherapy notes if not indicated on this form.**

